OPEN MINUTES - NJ STATE BOARD OF MEDICAL EXAMINERS
DISCIPLINARY MATTERS PENDING CONCLUSION - November 4, 2015

A meeting of the New Jersey State Board of Medical Examiners was held on Wednesday, August 12, 2015 at the Richard J. Hughes Justice Complex, 25 Market Street, 4th Floor Conference Center, Trenton, New Jersey for Disciplinary Matters Pending Conclusion, open to the public. The meeting was called to order by Karen Criss, R.N., C.N.M. Board Vice President.

PRESENT

Board Members Angrist, Stewart Berkowitz, Cheema, Criss, DeLuca, Haidri, Kubiel, Lopez, Maffei, McGrath, Metzger, Miksad, Miller, Rock, and Shah.

EXCUSED

Board Members Steven Berkowitz, Parikh, Rao and Scott.

ALSO PRESENT

Assistant Attorney General Joyce, Senior Deputy Attorneys General Dick, Flanzman and Gelber, Deputy Attorneys General Hafner, Puteska and Sauchelli, William V. Roeder, Executive Director of the Medical Board, Sindy Paul, M.D., Medical Director and Harry Lessig, M.D., Consultant Medical Director.

RATIFICATION OF MINUTES

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO APPROVE THE OCTOBER 14, 2015 OPEN BOARD MINUTES FOR DISCIPLINARY MATTERS PENDING CONCLUSION.

HEARINGS, PLEAS AND APPEARANCE

10:30 AM THOMAS, Eric, M.D., 25MA08857700
Complaint #96131
Michael Keating, Esquire for Dr. Thomas
Jillian Sauchelli, DAG, Prosecuting
Steven Flanzman, SDAG, Counseling

The Acting Attorney General filed an Order to Show Cause and Verified Complaint, with accompanying letter brief and exhibits, seeking the Temporary Suspension of Dr. Thomas' license to practice medicine and surgery in the State of New Jersey. The Complaint was based on allegations that Dr. Thomas failed to adhere to the appropriate standards of medication management in his prescribing of CDS, including his failure to employ safeguards necessary, such as, drug screens, pain management agreements and the use of the Prescription Monitoring Program, in order to prevent drug abuse and/or diversion of prescription medications. Oral Argument had been scheduled on the Order to Show Cause at the October Board meeting, however, due to an issue relating to the patient records, the matter was adjourned until October 22, 2015 before a Hearing Committee of the Board.

The Temporary Suspension Hearing on October 22, 2015 also was adjourned until this meeting. The Hearing Committee instructed the parities to continue to seek to mutually agree on the precise contours of Dr. Thomas' patient records. Those jointly submitted records were submitted to the Board members for this meeting. Additionally, the Hearing Committee also encouraged the parties to continue to explore an interim resolution of the matter. A resolution was not reached, so oral argument was

scheduled to proceeded at the November 4th meeting.

The Chair of the Hearing and Vice President of the Board, Ms. Karen Criss, opened the hearing providing background on the matter. After the parties put their appearances on the record, the continued hearing in this matter began.

SDAG Flanzman noted for the record that the joint record which the parties agreed upon was the complete copy of Dr. Thomas' records and that they would be accepted and entered into evidence. Accordingly, the two sets of records from the last meeting will be destroyed and would no longer be part of the official record; only those entered at the November meeting were considered as part of the official record.

Mr. Keating, attorney for Dr. Thomas, noted that since the October meeting, he had the case reviewed by an expert and asked that his submissions be updated with the inclusion of Dr. Scotti's report. Hearing no objection by the Attorney General, the Board supplemented the materials and it was marked as R-1 and R-2 (Report and CV) and admitted into evidence.

DAG Sucheilli also moved into evidence an addendum to Dr. Thomasen's expert report. Hearing no objection, it too was admitted into evidence.

The Board members were provided copies of the Joint records, Dr. Scotti's report and Addendum to Dr. Thomasen's report prior to the Board meeting.

The cross examination about Patient KG continued. Dr. Thomas acknowledged that he did not enter into a formal agreement pain management contract with him and he further acknowledged that

the patient had a positive for cocaine and that he continued to prescribe oxycodone to him. There was a second positive urine for morphine which was not a medication that was prescribed for him, and the positive test result, Dr. Thomas opined, may have been from a poppy seed bagel. In addressing the INR, KG only had one therapeutic level because he was continuing to adjust the medication to try and get him therapeutic. DAG Sucheilli pointed out in his record the number of times over a year period (generally within one month intervals) in which he was not therapeutic.

When questioned about his initial examination of a new patient, Dr. Thomas told the Board that he takes a complete history, performs a physical examination, arrives at a tentative diagnosis, order tests if needed, and orders initial treatment. When he looked at the record for the initial visit of KG, Dr. Thomas could not explain why the record did not reflect the complete exam that he performs all the time. He acknowledged that he did not write the history as reported by the patient. He tried to explain this away as this initial exam record was not his standard. Board members, upon questioning, pointed out a number of inaccuracies in his record that were contrary to, and inconsistent with, his prior testimony concerning what he does during an initial examination and in follow up visits. He also acknowledged a number of occasions in which a pain scale was never noted, yet he was prescribing CDS. Dr. Thomas told the Board that his policy on urine testing is that he takes one on almost each visit and if he suspects something, he counsels the patient, although when pressed with positive urine screens for cocaine on this patient, there was no reference in the record to the counsel. Dr. Thomas claimed he spoke to the patient, but did not document it and continued to explain his general practice is that after counseling, if

a positive recurs, he talks to the patient about referral to a pain management specialist and if necessary, he would discharge the patient from the practice. Dr. Thomas agreed with the observation that a subsequent health care provider would not have an accurate picture of this patient based on his medical record. He stressed that while information may not be documented in the records, he always lives by his standard protocols.

Turning his attention again to Patient KG, upon further questioning by his attorney, Dr. Thomas told the Board he prescribed Tramadol because the prior medications were not working, and given his history, he started him out with that. After about five or six months, when it became clear the Tramadol was not effective, he began to use a cocktail of other medications and he changed the dosage as needed until the Patient received some relief. Dr. Thomas believed he followed his standard protocol of pain management as described earlier in his testimony. As he continued to evaluate the patient, he also sought to ensure that he was not doctor shopping by regularly conducting PMP audits of his medications. When he had reason to believe that this patient was taking illicit drugs, as he testified, he counseled him and gave him another opportunity to become compliant. He also continued to treat him for his other illnesses, such as the diabetes and high blood pressure, for which he was watched very closely. During his course of treatment, this patient also developed some cardio vascular issues and he was referred out for that issue as well in April 2015. Dr. Thomas also noted that the patient was somewhat noncompliant and was resistant to following up with his orthopedist because he did not believe that it would help any.

JW was the next patient upon which Dr. Thomas testified and

thoroughly disagreed with the opinion of Dr. Thomasen. Dr. Thomas took issue with the assertion that he did not treat JW's hypertension. He outlined the various factors that are considered in making this diagnosis. JW was a 27 year old, African American male. While his blood pressure, at the initial appointment, was a bit high, Dr. Thomas told the Board that he does not rush to judgment but rather looks to see if there is a pattern more than three or so visits. He ultimately concluded that he was not hypertensive, although, he did continue to monitor him. Dr. Thomas noted in various parts of the chart to substantiate his conclusion. According to his testimony, JW did not have consistent hypertension as he was watched over a number of visits and he did not have sufficient risk factors to meet the medical criteria of hypertension. After the physical examination on the first visit, he diagnosed him as having pharyngitis. Unlike in the case of KG, he did document the full physical examination, including the straight leg exam not documented in the other case. Dr. Thomas asked the Board to recognize that this record was more typical of his documentation which is standard in his general practice.

Concerning the narcotics he was taking prior to coming to his initial appointment, Dr. Thomas explained that he had planned on weaning him down off the narcotics. JW was uninsured so he was limited as what could be done from an imaging study perspective. He was referred to a pain management specialist because in Dr. Thomas' opinion, he believed that patient needed someone more specialized in this area of treatment. In the interim of the referral and appointment, Dr. Thomas did give him a prescription to act as a bridge in between appointments. Dr. Thomas recalled that he mentioned the option of physical therapy, however, he did not

document it in the record. Eventually, however, Dr. Thomas reduced him to almost zero but given his financial situation, JW kept going to the ER for his medications. Ultimately, he was discharged from his practice because of his noncompliance and refusal to follow up with referrals. As best as Dr. Thomas could recall, this patient appeared to be taking his medications as prescribed. This was confirmed, Dr. Thomas continued, through urine tests and the PMP. It did appear that although JW never asked for additional medications, it did appear that he would double up on medications from time to time and then go periods without.

On cross examination, Dr. Thomas acknowledged his lack of documentation on issues, which included, ignoring some information in the PMP that indicated that JW was receiving narcotics from eight and/or nine other prescribers consistently and negative urines for oxycodone that was being prescribed for him and that he continued to prescribe it. Again, although not documented in the record, Dr. Thomas maintained that he counseled the patient about the use of marijuana (THC) in the urine tests. He did not have an explanation as to why he did not discharge the patient other than he was trying to wean him down and get him to participate with a pain management specialist. He agreed that it is not his standard practice to check with prior medical providers, in particular, as it relates to pain medications. In addressing the issue about hypertensive, he acknowledged he put that in his chart, however, he did not treat him for it. As JW's blood pressure was running sporadically through his course of treatment, Dr. Thomas explained that in the chart it is noted so that he will be reminded to keep a watch on it at the next follow up. When pressed, he agreed that more often than not, the

pressure was high. He also acknowledged that no EKG and/or lab work were done. Dr. Thomas stressed that given JW's non insured status he was not going to treat it when the numbers were all over the place. His only risk factors were that he was an African American and he was smoking marijuana and when pressed, he equivocated on his position.

Patient RH was next addressed who, according to Dr. Thomas, initially was seen in June 2013 when he performed a complete physical and took the history. RH was a fifty two year old male with hypertension, diabetic and ten out of ten back pain with eight out of ten knee pain. He was first diagnosed with tender to palpation; sensitivity when twisted; straight leg test was not documented, but performed.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO MOVE INTO CLOSED SESSION FOR ADVICE OF COUNSEL.

All parties, except Administrative and Counseling Staff, left the room. Returning to open session, the hearing continued.

SDAG Flanzman noted that the copies before the Board members for RH were not completely scanned. Copies were made and while that occurred, Mr. Keating moved on to another patient, MG and resumed his questioning on RH later in the proceedings.

MG was first came to him back in Feb 2014. The patient was self-referred and complained of back pain and occasional abdominal pain. After performing a physical and social history of MG, Dr. Thomas concluded that the 43 year old white male, with a past history of heroin addiction, currently on methadone, with occasional use of alcohol, suffered from back pain. He acknowledged that the record did not contain information of prior

courses of therapy to alleviate the lumbar back pain. Dr. Thomas told the Board that he discussed with the patient his history of addiction. Dr. Thomas maintained that he was able to reduce the quantity of methadone to, ultimately, no narcotics.

On the initial visit, his blood pressure was elevated and Dr. Thomas explained that he wanted to wait until another visit to assure that he was not suffering from "white coat" syndrome. During his course of treatment, he also treated him for sinusitis. Dr. Thomas disagreed with the State's expert's assertion that he ignored his hypertension. To the contrary, Dr. Thomas noted in the record how he recorded and watched his blood pressure readings over the course of treatment. While he did not treat him with any medication, Dr. Thomas assured the Board that he was vigilant in watching the readings and noting them at each visit. Overall, his readings were within the normal range. He had a few risk factors, such as age, family history, race, diabetes, weight, drug use, but in conjunction with the readings, he conservatively treated him and over time, became less and less concerned about it. Again focusing on the blood pressure issue, Dr. Thomas noted that as the records demonstrated, he followed the patient on this issue at each reading. He did note that the blood pressure did rise when he was increased pain medications as he attempted to wean him off the medications (April 2014 to Jan 2015), but this then returned to a normal range following February 2015 and this continued until his last visit in May 2015. Dr. Thomas once again explained away the positive for cocaine/morphine by believing that it might have been from a poppy seed bagel based on the threshold level of the results. The patient's last appointment was in May when he had gotten off the narcotics and no longer required follow up.

On cross examination, Dr. Thomas acknowledged that MG used ten bags of heroin at his height of addiction and Dr. Thomas was not prescribing him any methadone, although, he did counsel him on the issue. When he reviewed a prescription of the methadone, he thought he might have done one or two prescriptions to hold him over. Even though there were urine drug screens that were positive for cocaine, he continued to prescribe him methadone. On methadone prescriptions, Dr. Thomas noted that the patient also suffered from abdominal pain, although there were not notes of that in the patient chart, and he could not explain the discrepancy other than as he was writing out the script, the patient told him about it. In looking at the patient intake form, Dr. Thomas acknowledged that it stated that he used heroin daily which was contrary to his testimony that he wasn't using it and the urine monitoring turned up negative for the heroin. His medical record charts it as the patient was using, not used. Although MG was not a cash patient, Dr. Thomas had no explanation as to why diagnostic testing was not ordered and he could not explain why there was no follow up with the negative results of his liver function tests, nor any screening for hepatitis B or C, and HIV. While he did it initially, there were not any follow up with any diagnostic testing on the liver function tests. Dr. Thomas also failed to notify the DMV that he was on methadone without any plausible explanation as to why not. In follow up, Mr. Keating tried to clarify that the patient was not started on methadone by Dr. Thomas, or at least Dr. Thomas did not believe that he did. In looking at the record, while he was aware that MG was attending clinics, Dr. Thomas further acknowledged that nothing reflected that in the record. He also acknowledged that he did not refer him to any drug addiction counseling because the patient indicated

that he was attending clinics on a regular basis. Moreover, he honored his patient's wishes in that he wanted to do it on his own and locally.

Returning to RH, Dr. Thomas testified that the patient came to him June 2013. RH was a 52 year old, white male with coronary artery disease, diabetes presenting with back and knee pain. The back pain was better on resting and the knee pain was worse with walking but both were better with medications. He was a nonsmoker and did not consume alcohol and his blood pressure was within normal range. Additionally, RH was on Plavix and metformin. Previously, he had been prescribed narcotics by another physician. As was his usual practice, Dr. Thomas told the Board that he informed the patient about doctor shopping and/or diverting the medications and the implications of doing so. There was a contract, although as with all of his pain management patients, there was one implied in his treating and as a result of his counseling. He ordered lab work and followed up on it at the next visit, which according to Dr. Thomas, indicated an elevated A1C, for which he prescribed medications.

According to the State's expert, he claimed that there were only two entries in the chart that addressed his diabetes. Dr. Thomas noted other entries in the chart which proved that allegation untrue. Dr. Thomas believed that his treatment was appropriate, however, the patient did not necessarily follow the treatment plan. As needed, Dr. Thomas testified that he adjusted the medication as appropriate. Ultimately, he discharged the patient for two reasons. He was non-compliant with his physical therapy and he was not being truthful about his sugars. The patient reported fasting levels which were highly inconsistent with the A1C

readings he obtained. Dr. Thomas also pulled a PMP and noted that he was getting some CDS medications from other practitioners, namely his cardiologist. While Dr. Thomasen claimed he was not treating his CHF, Dr. Thomas noted where in the chart he noted this and although not directly following him on the CHF, he did keep it in mind when physically examining him, reviewing test results and the progress, or lack thereof, that he was making. Focusing on his treatment of his pain, initially Dr. Thomas maintained him on the regime with which he initially presented. He slowly increased the dosage until he became therapeutic. In checking the PMP, Dr. Thomas noticed that he had been using two different names/birth dates and looking at both reports, he was doctor shopping. Dr. Thomas continued by explaining that he dismissed RH, after referring him to a pain management specialist and physical therapy, which he continued to miss.

On cross examination, Dr. Thomas confirmed that he was prescribing medications for pain even though he had not done any diagnostic testing or confirmatory tests. Dr. Thomas also clarified that the pain management contract was entered eight months after he had begun to prescribe opiates. Again, he reviewed his care of RH's diabetes and stressed to the members of the Board that he was working with him based on the information albeit false. When he learned that he had been lying about his fasting levels, Dr. Thomas again reiterated that he dismissed him as a patient. At last month's hearing, Dr. Thomas testified that when a patient has an A1C of 11 or higher, he sees them on a weekly basis, although in the case of RH there were longer periods between the follow up appointments. When pressed, he also acknowledged that he saw the patient three or four times before he recorded

and/or noted his fasting sugars. Dr. Thomas continued to maintain that although not documented in the record, he counsels his patients on a regular basis.

MOTION MADE AND SECONDED, THE BOARD VOTED TO MOVE INTO CLOSED SESSION FOR ADVICE OF COUNSEL.

All parties, except counseling and administrative office, left the room. Returning to open session, it continued with the hearing.

Patient GP was discussed next. The patient, in 2013, presented with back pain post-surgery which was worse while sitting though she did improve with movement and medication. He performed a physical exam and took the social history. The patient brought in a May, 2012 MRI and an EMG record – both of which identified the disc issues. While her blood pressure was slightly elevated, she was not being treated with blood pressure medication. Dr. Thomas also performed a straight leg test with a positive twist. When she presented, she was on pain medication from another prescriber. He diagnosed her with back pain and anticipated treating her both for her pain and as her primary care physician. Dr. Thomas estimated about 20% to 25% of his patient population consists of a pain management practice that received narcotics. Dr. Thomas informed the Board, that because of her chronic pain from the discectomy he continually monitored her blood pressure, although he never treated it with medication.

As with some of the other patients at issue, patient GP's blood pressure readings were sporadic, but generally on the lower side. He also treated her hip and neck pain secondary to the back issues. During Dr. Thomas' course of care, this patient had a

traumatic accident to her face in which a lot of cheek had been removed. She was referred to plastic surgeon for continued care. In treating her pain, Dr. Thomas testified that after performing the straight leg test, as was his usual practice, he started her out on minimum amounts of medication. She did, however, have two "dirty" drug screens (positive for heroine) and again, according to Dr. Thomas, he counseled her and referred her to a pain management specialist. These happened within six months of his initial visit. As he testified to earlier, he discussed that in the event the patient uses illegal drugs and/or doctor shops, he counseled on the first slip and then discharges them if it reoccurs. GP had some difficulties finding another pain management doctor and while he continued to treat her but he continued to decrease her dosage at each visit. Simultaneously, he treated her medically and while he was decreasing her dosages awaiting a new doctor, he continued to take her urine screens and they continued to be clean. On cross examination, DAG Suchelli questioned the Respondent about his prescribing and he acknowledged that he continued to treat her after her dirty urines. Dr. Thomas also acknowledged that he treated this patient differently than the usual protocol he described at the last hearing. For example, Dr. Thomas testified that he started with 5 mg and titrated up. Contrary to that testimony, GP was prescribed 30 mg, 80 pills on the first visit. He also when pressed clarified that the urine contained cocaine, heroin and no oxycodone, even though he was continuing to prescribe it for her. The same was true for the second dirty urine, except this also included morphine, which he was not also prescribing. He did not have any explanation as to why he failed to reach out to prior prescribers when a new patient presents, even though the PMP indicates the history. Dr. Thomas

believed even though there was not oxycodone in the urine, he was trying to manage the bridge and when pressed further, he had no explanation as to what that would be a good practice.

Moving to patient LK, Dr. Thomas told the Board that he treated her for four months but she left his care because he no longer was prescribing narcotics to her. Initially, he discovered that this 29 year old white female that presented with congenital blood disease and two vertebrae with significant back pain, worse with sitting for periods of time who experienced some improvement with heat. Her pain scale was eight out of ten. Significant in her history, she reported the disc disease, but it was unclear until physical examination. According to Dr. Thomas, he had requested a copy of a previously completed MRI, however she failed to provide it to him. At the time of presentation, she was taking narcotics (oxycodone, 3mg 4x day). His diagnosis included pain in her back (lumbar radio) and he prescribed a short script for narcotics. Even though he continued her treatment of medications, her symptoms remained the same. When he attempted to lower her dosage and prescribe anti-inflammatory medication, he was met with resistance and began scheduling her for two week intervals and then three. Dr. Thomas ran a PMP audit which indicated that he was the only doctor prescribing to her at the time. Additionally, he requested urine drug screens and she failed to have them done. After he realized this about two months into his treatment he began to start moving her out of his practice to another pain management specialist. Eventually, due to her lack of cooperation and his counseling, he discharged patient LK from the practice. On cross examination, he agreed that he did not follow what he testified to as his standard protocol in treating pain in his patients. He also acknowledged that he did not perform any

diagnostic testing on the patient.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO MOVE INTO CLOSED SESSION FOR ADVICE OF COUNSEL. IT CARRIED UNANIMOUSLY.

All parties, except counseling and administrative staff, left the room.

RETURNING TO OPEN SESSION, THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO INFORM THE PARTIES THAT THE BOARD DECIDED THAT THERE WAS SUFFICIENT EVIDENCE PRESENTED IN ORDER TO MAKE A DECISION BASED ON THE SIX PATIENTS PREVIOUSLY DISCUSSED AND PRESENTED.

The Motion was made by Ms. Kubiel and seconded Ms. Lopez; the motion carried unanimously.

The parties were requested to give brief closing arguments.

In closing, Mr. Keating asked the Board to look at the six cases against the overall practice of Dr. Thomas. Mr. Keating recognized the impact that this decision has on this doctor's practice, as well as his patients, but such a decision cannot be founded on broad based statements and incomplete records. He also took issue with Dr. Thomasen's expert report which he had reason to believe was based on an incomplete record. Mr. Keating asked the Board to recognize that the Attorney General has not met its high burden of proof in demonstrating a palpable demonstration of imminent harm to the public.

Mr. Keating told the members of the Board that when it reviews

the totality of the evidence, they will conclude that Dr. Thomas provided not only good medical care, but also appropriate prescribing under the presenting symptoms. He stressed that any time Dr. Thomas had reason to believe that the patient was not being compliant, whether medically or with narcotics, he altered his care and treatment of the patient, even to the point of discharge. Mr. Keating continued by arguing that the Verified Complaint and Expert Report were based on incomplete records, which was demonstrated by the efforts it took for the parities to agree on a joint record, and he maintained was markedly different than what was presented to the expert. At best, Mr. Keating argued that this was a case about poor record keeping. While the records do not clearly indicate all the care that was provided, Dr. Thomas' testimony filled in the gap and Mr. Keating asked the Board to consider that totality in deciding that his practice does not demonstrate a palpable demonstration of imminent harm.

DAG Suchelli argued that the evidence demonstrates a severe lack of knowledge in record keeping, the practice of medicine and CDS prescribing and cited examples of each claim in the patient charts. DAG Suchelli claimed Dr. Thomas also failed to do a proper exam and/or order follow up tests and noted the countless times he ignored a number of poor blood pressure readings and A1C. While Dr. Thomas tried to explain away the issues with his testimony, DAG Suchelli referred the Board to the record which was replete with failures to practice good medicine. Dr. Thomas also ignored drug seeking behaviors and even when he had positive urine test, he continued to prescribe multiple scripts. She acknowledged that while he ran PMP reports, he failed to use the information that he learned and it appeared that he believed that because he ran the reports, he could ignore objective evidence of

drug seeking behavior. Even when illegal substances were found, he claimed that he was referring them out to pain management specialists, yet there is nothing in the record to indicate his discharge. Another example where he ignored test results with the INR, in that he continued to get non therapeutic levels, yet did little to nothing to change the medications so that the patient would fall within appropriate levels. She disagreed with Mr. Keating's charge that this was simply a case about poor record keeping, but rather grossly negligent practice of medicine outlining many of the failures of his practice. She urged the Board to temporarily suspend Dr. Thomas' license to practice medicine and surgery.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO MOVE INTO CLOSED SESSION FOR DELIBERATIONS AND ADVICE OF COUNSEL.

The motion, which was made by Dr. Berkowitz and seconded by Dr. Angrst, carried unanimously. All parties, except counseling and administrative staff, left the room. Returning to open session, it announced its decision.

BASED ON THE CONSIDERATION OF ALL THE EVIDENCE PRESENTED AS TO ALL COUNTS OF THE COMPLAINT, THE BOARD FINDS THAT THE ATTORNEY GENERAL HAS MET THE STATUTORY BURDEN OF PALPABLY DEMONSTRATING THAT THE CONTINUED PRACTICE OF DR. THOMAS PRESENTED AN IMMINENT DANGER TO THE HEALTH, SAFETY, AND WELFARE WITHOUT LIMITATION BY CONSISTENTLY DEMONSTRATING AN APPALLING ABSENCE OF MEDICAL JUDGMENT, INADEQUATE PHYSICAL AND HISTORY PERFORMANCE, FAILING TO MAINTAIN

ACCURATE MEDICAL RECORDS, FAILING TO SECURE PRIOR RECORDS OF OPIATE TREATED PATIENTS, UNTIMELY TESTING AND LACK OF APPROPRIATE FOLLOW UP TO ABNORMAL FINDINGS THAT COULD PRESENT AN IMMINENT THREAT. IN SPITE OF HIS TESTIMONY TO THE CONTRARY, HE REPEATEDLY STARTED PATIENTS ON HIGH DOSES OF CDS AND CONTINUED TO PRESCRIBE EVEN AFTER EVIDENCE OF ABUSE AND/OR DIVERSION, WHICH INCLUDED DIRTY URINE SCREENS DEMONSTRATING ILLEGAL DRUGS AND NOT TAKING MEDICATION BEING PRESCRIBED AND DEMONSTRATION OF A COMPELLING AMOUNT OF EVIDENCE OF ABUSE. GIVEN THESE FINDINGS NO ACTION SHORT OF A TEMPORARY SUSPENSION WOULD BE ADEQUATE TO PROTECT THE PUBLIC. IN ORDER TO TRANSITION CARE OF EXISTING PATIENTS, DR. THOMAS HAD 30 DAYS, (UNTIL THE CLOSE OF BUSINESS ON DECEMBER 4, 2015) PRIOR TO THE EFFECTIVE DATE OF HIS SUSPENSION. IN THE INTERIM PERIOD, DR. THOMAS WAS NOT PERMITTED TO ACCEPT ANY NEW PATIENTS AND MUST MAKE APPROPRIATE TRANSFER OF HIS PATIENTS TO ANOTHER HEALTHCARE PROVIDER.

The Motion was made by Ms. Lopez and seconded by Ms. Kubiel; it carried unanimously.

This concluded the hearing.

OLD BUSINESS

Nothing Scheduled.

NEW BUSINESS

Nothing Scheduled.

Respectfully submitted,

Karen Criss, R.N., C.N.M.
Vice President

WVR/br